

Reducing Medication Errors in Hospitals National Summit 2016

10% card payments discount*
15% Group booking discount**

Wednesday 22 June 2016 Hallam Conference Centre, London



Chair and Speakers Include:

David Heller

Chief Pharmacist

Surrey and Sussex Healthcare NHS Trust

David Gerrett

Senior Pharmacist Medication Safety Team

NHS England (invited)

Supporting Organisation



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**“It’s a learning curve for everybody to ensure patients are receiving harm free care”
Ahmed Ameer Medication Safety Officer NHS England January 2015**

“Progress has been made over the last decade to detect, report and learn from patient safety incidents, but further improvements are needed to increase the number of incident reports, improve data quality and maximise what is learned from medication errors....Medication errors are any patient safety incidents where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines.” Patient Safety Alert, MHRA and NHS England

This Summit aims to bring together clinicians, managers and medication safety officers to understand current issues and the national context, and to debate and discuss key issues and areas they are facing in improving medication safety and reducing medication errors. Following National Update sessions, key areas will focus on reporting of medication incidents, developing the role of the medication safety officer, managing a medication incident, developing a medication error reduction programme, reducing medication errors on the ward, reducing prescribing errors and learning from medication errors and communication of medication errors and safety alerts: getting the message across to frontline staff to learn and improve practice.

A final interactive session will provide a step by step guide to incident investigation and root cause analysis of medication safety incidents.

100% of delegates at our last conference on Reducing Medication Errors would recommend the conference to a colleague.

Follow the conference on Twitter #MedicationErrors

10.00 Chair's Introduction

David Heller *Chief Pharmacist Surrey and Sussex Healthcare NHS Trust*

10.10 Reducing Medication Errors: National Update

David Gerrett
Senior Pharmacist Medication Safety Team
NHS England (invited)

- the development of the National Medication Safety Network
- improving the number, quality, timeliness of reports
- maximising local learning and actions
- omitted medicines and medication errors
- developing the role of the medication safety officer
- learning from patients to reduce medication errors

10.40 Reducing Medication Errors in Practice: Improving reporting and learning systems

Speaker to be announced

- developing a culture of patient safety from board to ward
- improving reporting and learning systems
- how do we reduce, and monitor the reduction in Medication Errors
- priority areas: where should efforts be focused?
- what are the root causes of medication error: our experience and learning

11.10 *Questions & answers, followed by tea & coffee at 11.20*

11.45 Developing the role of the Medication Safety Officer: Extended Panel Session

Panel Members will give 15 minute presentations discussing the role, what has worked and the challenges they are facing with tips for developing the role in practice – followed by interactive discussion.

Joanna Taylor *Lead Pharmacist – Medication Safety Risk and Compliance Central and North West London NHS Foundation Trust*
David Walker *Medication Safety Officer Alder Hey Children's NHS Foundation Trust*

12.40 Reducing prescribing errors

Indi Sanghera
Project Lead Prescribing Improvement Model
Centre of Medication Safety
& Service Quality and Project Lead
Imperial College Health Partners (AHN)

- roll out of the Prescribing Improvement Model to North West London Hospitals
- improving pharmacists' feedback to doctors on their prescribing errors
- improving identification of prescribers
- reducing prescribing errors by means of a 3 part intervention

13.10 *Questions & answers, followed by lunch 13.20*

14.00 Managing a medication incident

Elaine Spencer
Serious Incident Investigator
Brighton and Sussex University Hospitals Trust

- managing a medication incident
- ensuring adherence to the Duty of Candour
- interviewing staff involved in serious incidents
- liaising with patients and families
- recognising trends and patterns in the data
- case studies and examples in practice

14.25 Eliminating Medication Errors on the Ward

Helen Young
Chief Nurse
Birmingham Womens NHS Foundation Trust

- practical strategies for reducing medication errors on the ward
- monitoring medication errors at ward level and delivering change
- our experience in Birmingham

14.50 Learning from medication errors and communication of medication errors and safety alerts: Getting the message across to frontline staff

Maddy Woods
Consultant Nurse
Homerton University Hospital NHS Foundation Trust

- how do we effectively communicate the learning from medication errors, and safety alerts to frontline staff
- ensuring learning and action plans leads to change in behaviour and practice
- accountability for action plans and ensuring change happens

15.15 *Questions & answers, followed by tea & coffee 15.30*

16.00 EXTENDED SESSION: Skills Development Incident Investigation & Root Cause Analysis of Medication Errors

Simon Robinson
Barrister
Accredited Mediator Five Paper Chambers

- a step by step guide to undertaking an incident investigation and RCA for medication error
- systems and good practice for medication errors incident reporting
- tools and techniques for effective Root Cause Analysis

17.00 *Questions & answers, followed close 17.10*

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Conference Registration

Hallam Conference Centre, London

Download

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For more information contact Healthcare Conferences UK on **01932 429933** or email jayne@hc-uk.org.uk

Venue

Hallam Conference Centre, 44 Hallam Street, London, W1W 6JJ. A map of the venue will be sent with confirmation of your booking.

Date Wednesday 22 June 2016

Conference Fee

- ☐ £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and universities.
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